

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

**Rhode Island Department of Health
Office of HIV/AIDS & Viral Hepatitis
Surveillance Program
Tel: 401-222-7541
401-222-7543**

The Adult HIV/AIDS Confidential Case Report form has been updated to include HIV infection with patient's name. This form is to be used to report both HIV infection and AIDS disease with name along with the unique identifier used previously. Please note HIV infection reporting will now include patient name and other relevant patient information.

Instructions for including the patient's name and creating the unique identifier code is inside the form. Detailed instructions and guidance for completing the form will be available at most agencies and clinics treating people with HIV and AIDS. For additional information about reporting procedures and recent changes please contact the Office of HIV/AIDS & Viral Hepatitis. For this form and the AIDS Laws please go to the health web site: HIVINFORI.org

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT
RHODE ISLAND DEPARTMENT OF HEALTH
Office of HIV & AIDS
Telephone: (401) 222-7541, (401) 222-7543

As of July 1st 2006, the Rhode Island Department of Health is implementing a new Name Based HIV surveillance system. This new system improves our ability to quantify the number of individual cases of HIV infection. From now onwards, AIDS and HIV cases, both will continue to be reported with names as well as with the existing unique identifier. This new version of the Adult HIV/AIDS Confidential Case Report form should be used to report both HIV infection and AIDS cases with name along with the code. Please follow the steps to fill out patient name and the code in the form.

Step 1: Please write down the the Patient name in section: 1

Step: 2 Please follow the instructions below to create the Unique identifier code and write that down in section: VI

Instructions for Creating the Unique Identifier Code

VI. FOR HIV & AIDS - MUST BE COMPLETED - ESSENTIAL INFORMATION

First 2 letters of First Name	Numbers of Letters in Last Name	Sex	Date of Birth	Last 4 Digits of Social Security Number	Zip Code of Residence
		Male 1 Female 2	Month Day Year		

The information in Section VI. makes up the unique identifier code used to report HIV cases in Rhode Island. Complete all sections. The following are special instructions for the sections involving patient names. More detailed instructions can be found on the RI Department of Health's website (<http://www.doh.state.ri.us>).

- Name Related Fields:

Use the first two letters of the first name and the number of letters in the last name as the name appears in the medical record.

First names: **DO NOT** use a nickname unless it represents the patient's name of record. If the first name of record is an initial only, disregard it and enter the first two letters of the next name in sequence. For example: T. Walter Smith = WA 5

Last names: Count all letters in last name(s), ignoring hyphens, apostrophes, spaces or periods.

Example 1: John Doe = JO 3

Example 2: Charlie McCarthy = CH 8

Example 3: Jane O'Brien = JA 6

Example 4: Al Smith-Jones = AL 10

Example 5: Susan St. James = SU 7

Example 6: Anna Lopez Sanchez = AN 12

Example 7: T. Walter Smith = WA 5

- Last 4 digits of Social Security Code:

If individual does not have a social security number, enter "9" in all four boxes.

Example:

Last 4 Digits of Social Security Number			
9	9	9	9

- Zip Code of Residence:

If individual is homeless, enter "8" in all five boxes.

Example:

Zip Code of Residence				
8	8	8	8	8

Mail completed forms in the envelope provided or mark your envelope **"CONFIDENTIAL"** and send to:

RHODE ISLAND DEPARTMENT OF HEALTH
Office of HIV/AIDS & Viral Hepatitis, Surveillance Program
3 Capitol Hill, Room 106
Providence, RI 02908-5097

DATE FORM COMPLETED:		
Mo.	Day	Yr.
<input type="text"/>	<input type="text"/>	<input type="text"/>

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

(Patients >= 13 years of age at time of diagnosis)

Rhode Island Department of Health

Office of HIV/AIDS

Tel: 401-222-7541 & 401-222-7543

DIAGNOSIS STATUS AT REPORT

- ☐ 1 HIV Infection only
☐ 2 AIDS

HEALTH DEPARTMENT USE ONLY	
Soundex Code:	State Patient No:
<input type="text"/>	<input type="text"/>

PATIENT BARCODE/NUMBER	
<input type="text"/>	<input type="text"/>

I. ESSENTIAL INFORMATION- FOR ALL CASES

Patient's Name _____	Medical Record No. _____
Address _____	
Phone No: () _____	Social Security # _____

II. DEMOGRAPHIC INFORMATION

TYPE OF REPORT <input type="checkbox"/> Initial/New HIV diagnosis <input type="checkbox"/> Previously diagnosed HIV	<input type="checkbox"/> Initial/New AIDS <input type="checkbox"/> Previously Diagnosed AIDS	STATE/TERRITORY OF DEATH _____	AGE AT DIAGNOSIS: _____ Years	CURRENT STATUS: Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unk. <input type="checkbox"/>	DATE OF DEATH: Mo. _____ Day _____ Yr. _____
ETHNICITY <input type="checkbox"/> 1 Hispanic <input type="checkbox"/> 2 Not Hispanic or Latino <input type="checkbox"/> 9 Unknown	RACE <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian or Pacific Islander <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Unknown	GENDER <input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female TRANSGENDER <input type="checkbox"/> MTF <input type="checkbox"/> FTM	COUNTRY OF BIRTH: <input type="checkbox"/> 1 U.S. <input type="checkbox"/> 7 U.S-Possession specify _____ <input type="checkbox"/> 8 Other (specify country): _____		

RESIDENCE AT DIAGNOSIS:	City: _____	County: _____	State/Country: _____	Zip Code: _____
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III. FACILITY OF DIAGNOSIS

Facility Name _____
City _____
State/County _____
FACILITY SETTING (check one)
<input type="checkbox"/> 1 Public <input type="checkbox"/> 2 Private <input type="checkbox"/> 3 Federal
<input type="checkbox"/> 9 Unknown
FACILITY TYPE (check one)
<input type="checkbox"/> 01 Physician, HMO <input type="checkbox"/> 32 Hospital, Outpatient
<input type="checkbox"/> 22 HIV Test Site <input type="checkbox"/> 33 Emer. Room
<input type="checkbox"/> 23 STD Clinic <input type="checkbox"/> 34 Laboratory
<input type="checkbox"/> 24 Drug Trmt. Ctr. <input type="checkbox"/> 35 Blood Bank
<input type="checkbox"/> 26 Pre-Natal/OB Clinic <input type="checkbox"/> 38 Ped HIV Clinic
<input type="checkbox"/> 28 TB Clinic <input type="checkbox"/> 39 Adult HIV Clinic
<input type="checkbox"/> 30 Corr Facility <input type="checkbox"/> 41 Hemophilia Trmt.
<input type="checkbox"/> 31 Hospital Inpatient <input type="checkbox"/> 88 Health Center
<input type="checkbox"/> Other
Lab
Name: _____
Address: _____

IV. PATIENT HISTORY

Before the first positive HIV test or AIDS diagnosis, did this person have:

	Yes	No	Unk
Sex with male.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
Sex with female.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
Injected nonprescription drugs.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
Received clotting factor for hemophilia disorder.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
Specify <input type="checkbox"/> Factor VIII (Hemophilia A) <input type="checkbox"/> Factor IX (Hemophilia B) <input type="checkbox"/> Other (specify): _____			
HETEROSEXUAL relations with any of the following:			
Intravenous/injection drug user.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
Bisexual male.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
Person with hemophilia/coagulation disorder.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
Transfusion recipient with documented HIV infection.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
Transplant recipient with documented HIV infection.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
Person with AIDS or documented HIV infection, risk not specified.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
Received transfusion or blood/blood components (other than clotting factor).....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
Date of First _____ Mo. _____ Yr. _____ Date of Last _____ Mo. _____ Yr. _____			
Received transplant of tissue/organs or artificial insemination.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
Worked in a health-care or clinical laboratory setting.....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
(specify occupation): _____			

V. LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS: . HIV-1/2 EIA.Combination Antibody... . HIV 1 EIA.Antibody..... . HIV-1 Western Blot..... . HIV 1 IFA.....	Pos Neg Not Done <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9	TEST DATE Mo. _____ Yr. _____ Mo. _____ Yr. _____ Mo. _____ Yr. _____ Mo. _____ Yr. _____	. Date of last documented negative HIV test (specify type): . If HIV laboratory tests are not documented in record, is HIV diagnosis documented by a physician? If yes, provide date of documentation by physician.....	Mo. _____ Yr. _____ Yes No Unk. <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 Mo. _____ Yr. _____
2. POSITIVE HIV DETECTION TEST: (Record earliest test) . HIV PCR, DNA or RNA probe.....	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9	Mo. _____ Yr. _____	3. IMMUNOLOGIC LAB TESTS: (Most recent) . CD4 Count..... cells/uL . CD4 Percent..... % First <200 uL or <14% . CD4 Count..... cells/uL . CD4 Percent..... %	
3. DETECTABLE VIRAL DETECTION TEST: (Record earliest test) Test type* _____ COPIES/ML _____ * Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 18. Other	<input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9	Mo. _____ Yr. _____		

VI. ESSENTIAL INFORMATION FOR HIV CASES

First 2 letters of First Name	Number of Letters in Last Name	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth Month _____ Day _____ Year _____	Last 4 Digits of Social Security Number	Zip Code of Residence
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="text"/>	<input type="text"/>	<input type="text"/>

FOR WOMEN: This patient is receiving or has been referred for gynecological or obstetrical services:
. Is this patient currently pregnant?
. Has this patient delivered live-born infants?..... (Please provide birth information below for most recent birth)

CHILD'S DATE OF BIRTH Month Day Year **HOSPITAL OF BIRTH** Address Phone no. **HEALTH DEPARTMENT USE ONLY** Child's Soudex: Child's State Patient Number

VII. CLINICAL STATUS

CLINICAL RECORD REVIEWED: Yes No **ENTER DATE PATIENT WAS DIAGNOSED AS:** Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy): Mo. Yr. Symptomatic (not AIDS): Mo. Yr.

AIDS INDICATOR DISEASES	Initial Diagnosis Def. Pres.	Initial Date Mo. Yr.	AIDS INDICATOR DISEASES	Initial Diagnosis Def. Pres.	Initial Date Mo. Yr.
Candidiasis, bronchi, trachea, or lungs	1 NA		Lymphoma, Burkitt's (or equivalent term)	1 NA	
Candidiasis, esophageal	1 2		Lymphoma, immunoblastic (or equivalent term)	1 NA	
Carcinoma, invasive cervical	1 NA		Lymphoma, primary in brain	1 NA	
Coccidioidomycosis, disseminated or extrapulmonary	1 NA		Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary	1 2	
Cryptococcosis, extrapulmonary	1 NA		M. tuberculosis, pulmonary*	1 2	
Cryptosporidiosis, chronic intestinal (> 1mo. duration)	1 NA		M. tuberculosis, disseminated or extrapulmonary*	1 2	
Cytomegalovirus disease (other than in liver, spleen, or nodes)	1 NA		Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	1 2	
Cytomegalovirus retinitis (with loss of vision)	1 2		Pneumocystis carinii pneumonia	1 2	
HIV encephalopathy	1 NA		Pneumonia, recurrent, in 12 mo. period	1 2	
Herpes simplex: chronic ulcer(s) (>1mo. duration); or bronchitis, pneumonitis or esophagitis	1 NA		Progressive multifocal leukoencephalopathy	1 NA	
Histoplasmosis, disseminated or extrapulmonary	1 NA		Salmonella septicemia, recurrent	1 NA	
Isosporiasis, chronic intestinal (>1mo. duration)	1 NA		Toxoplasmosis of brain	1 2	
Kaposi's sarcoma	1 2		Wasting syndrome due to HIV	1 NA	

Def. = definitive diagnosis (lab confirmed) Pres. = presumptive diagnosis (clinical) * RVCT CASE NO.:
. If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition? 1 Yes 0 No 9 Unknown

VIII. TREATMENT/SERVICES REFERRALS

Has this patient been informed of his/her HIV infection? 1 Yes 0 No 9 Unk
This patient's partners will be notified about their HIV exposure and counseled by:
1 Health department 2 Physician/provider 3 Patient 9 Unknown

This patient received or is receiving:
. Anti-retroviral therapy..... Yes No Unk. 1 0 9
. PCP prophylaxis Yes No Unk. 1 0 9

This patient has been enrolled at:
Clinical Trial Clinic
1 NIH-sponsored 1 HRSA-sponsored
2 Other 2 Other
3 None 3 None
9 Unknown 9 Unknown

This patient is receiving or has been referred for:
. HIV related medical services..... Yes No NA Unk. 1 0 - 9
. Substance abuse treatment services 1 0 8 9

This patient's medical treatment is primarily reimbursed by:
1 Medicaid 2 Private insurance/HMO
3 No Coverage 4 Other Public Funding
7 Clinical trial/government program 9 Unknown

IX. PHYSICIAN/FACILITY INFORMATION

Physician's Name: Phone No.: Hospital/Facility:
(Last, First, M.I.)
Office contact person for partner notification Phone No.:
(if other than the person completing the form)

Medical Provider: To the best of my knowledge, I certify that the information supplied is correct.

Print Name Signature Date

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